



August 10, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin J. Walsh, Secretary of Labor
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

The Honorable Janet Yellen, Secretary of the Treasury
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

**RE: *No Surprises Act* Independent Dispute Resolution (IDR) Rulemaking**

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) would like to provide additional input as the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) continue implementation of the *No Surprises Act*—which was included in the *Consolidated Appropriations Act, 2021* (PL. 116-260). While we have positioned these comments related to the independent dispute resolution (IDR) process in light of the interim final rule with comment (IFC) released by the Departments, *Requirements Related to Surprise Billing; Part I,*[1]

[1] 86 Fed. Reg. 36,872 (July 13, 2021).

this letter is intended to inform your deliberations as you draft the provisions related to IDR that have yet to be released. We intend for this communications to complement our letter to the Departments delivered on March 24, 2021, portions of which focused on the IDR process.

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the nearly 150 million Americans we treat on an annual basis. EDPMA is the nation's largest professional physician trade association focused on the sustainable delivery of high-quality, cost-effective care in the emergency department (ED), and its members handle over half of the visits to U.S. emergency departments each year. Together, ACEP and EDPMA members provide a large majority of emergency care in our country, including rural and urban settings, in all fifty states.

ACEP and EDPMA have both strongly advocated for a comprehensive solution to addressing surprise medical billing (SMB), working with members of Congress to make sure that any such legislation would truly keep patients out of the middle of billing disputes, include fair payment mechanisms that ensure adequate reimbursement for out-of-network services, and promote a sustainable emergency care system. We believe that the *No Surprises Ac*t represents a reasonable solution to this issue, and we support the patient protections embedded in the law. We are appreciative that Congress promoted the process of open negotiation between payors and providers and included the back-stop of independent dispute resolution (IDR) to resolve lingering disputes between payors and providers to keep our patients "out of the middle." **We provide these comments to achieve two goals: (1) To build on the patient protections included in the *Requirements Related to Surprise Billing; Part I* IFC; and (2) Reduce overreliance on the IDR process as a means of resolving disputes.**

With those goals in mind, our letter is organized as follows:

**A.** *Reducing Reliance on IDR Through Requiring Plan/Issuer Early Provision of Accurate, Complete Information*

**B.** *Batching*

**C.** *90-Day Cooling Off Period*

**D.** *IDR Criteria & Deliberations*

**E.** *Additional Policies to Support an Effective Federal IDR System*

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## A. Reducing Reliance on IDR Through Requiring Plan/Issuer Early Provision of Accurate, Complete Information

**Plan/Issuer Communication Obligations**

ACEP and EDPMA believe that the process that the Departments put forward for federal Independent Dispute Resolution (IDR) will be crucial to fulfilling the goals of the *No Surprises Act*. We also believe that, while IDR is a vitally important mechanism, it should be a venue of last resort. Ensuring that timely, accurate information is supplied efficiently during the initial time periods involving payment and open negotiation is critical to making sure that IDR is utilized in as few disputes as possible. As the Departments continue to draft provisions related to the IDR process, ***ACEP and EDPMA urge the Departments to ensure that the information communicated throughout the No Surprises Act timeline be done so in a way that provides accurate information as completely and efficiently as possible so that parties can avoid IDR in as many instances as possible.*** The regulatory implementation of the law should not unintentionally overburden the federal IDR process.

As you are aware, prior to any initiation of IDR, the *No Surprises Act* provides for a 30-day open negotiation period. For as much attention has been paid to the IDR details, we believe the 30-day open negotiation period is a key component that can support the parties in dispute and help to avoid overreliance on the IDR process. In order for the 30-day negotiation to fulfill its goal of providing an opportunity to avoid IDR, ***ACEP and EDPMA urge the Departments to ensure that at the time of the initial adjudication of the claim, or as part of the remittance communication that is issued in connection with payment or denial, plans/issuers are required to communicate the Qualifying Payment Amount (QPA) for the Current Procedural Terminology (CPT®) code(s) as submitted by the provider on the claim, as well as other key pieces of information.*** It is particularly important to specify information that relates to the differences between the billed amounts on the provider's claim and the plan/issuer's initial payment (or denial). It is imperative that providers and facilities have this key information at the outset in order to optimize the 30-day open negotiation process and avoid engaging IDR wherever possible.

To demonstrate the value of providing key information as early in the process as possible, it is important for the Departments to understand the format in which providers and facilities receive information from plans/issuers. When providers receive information from plans/issuers via a remittance notice, plans/issuers often provide information on items and services they are paying or denying with the main commonality being the provider's or provider group's Tax Identification Number (TIN). However, in a single remittance notice, a plan/issuer will often provide:

- Information related to **multiple patients;**
- Information related to the furnishing of **multiple different items and services;**
- Information related to **multiple dates of service;**
- Payment information for **any of the different insurance products** offered by the plan/issuer; and
- **Different payment rates for the same CPT code** depending on the specific insurance product.

Note that this is a different organization of information than appears on a claim from the provider submitted to the plan for items or services, where the information relates only to a single patient

treated by that TIN (which may include multiple providers). In addition, given that information from multiple insurance products can be conveyed in a remittance communication from the plan/issuer to the provider/facility at the same time, the pathway for resolution could be different based on each insurance product, even with the same plan/issuer. Further, the same "item or service" with the same "plan" could have different QPAs based on the underlying insurance product, yet under the *No Surprises Act* language regarding batching for IDR, could proceed to IDR as part of the same "batch." This means that there are multiple QPAs that could apply to a single CPT code because of the multiple insurance products offered by that single plan. Evaluating the plan's treatment of an item or service requires that providers know what the QPA is for the "item or service" as billed by the provider, since providers must be able to see the differences between the QPAs by insurance product.

In light of these claims processing realities and in order to support open negotiation where necessary and avoid the use of IDR, ***ACEP and EDPMA urge the Departments to ensure that information from the plan/issuer be conveyed as promptly and specifically as possible (in relation to the claim that was submitted by the provider) at the time the claim is initially adjudicated*** (i.e., at the time the plan/issuer is required to render an initial payment or denial and no more than 30 days after receiving a claim). This information includes:

- The type of plan that covers each claim and the dates that each plan has opted into and out of any state laws;
- The resolution pathway that each item or service lives under (i.e., "Specified State Law" or federal IDR process)
- The QPA(s) for the items and services as billed by the provider: Given that these numbers will vary by insurance product, there could be multiple QPAs conveyed for the same CPT code on the same remittance communication from the plan/issuer, which could make it impossible for providers to evaluate the fairness, accuracy, and applicability of a QPA and assess the QPA relative to the initial payment amount made by the plan/issuer if it is not clear what the QPA is for the item or service as billed by the provider.
- The patient's copay, deductible, and coinsurance for each claim.
- Additional information that helps with the valuation of payment amounts should be routinely supplied in an easily accessible, machine-readable, downloadable format, including how the QPA(s) was calculated, an overall assessment of the number and size of contracts that were included in determining the QPA, the percentage of claims that were covered, the geographic area that was used, and the QPA and specific cost sharing amount for all items or services billed by the provider or paid by the plan/issuer.

Without this crucial information, it will be impossible for providers to assess the appropriateness and fairness of payment and the context in which providers/facilities will enter good faith negotiations with plans/issuers to avoid proceeding to IDR. For the negotiation process to work and to truly reduce overreliance on IDR, this information must be conveyed at the outset. In addition, **we cannot overstate the importance of the Departments requiring this information to be communicated in a standardized, efficient way (e.g., Remittance Advice Remark Codes (RARCs)/Claim Adjustment Reason Codes (CARCs)) so that systems can process the information without needing to wade through voluminous, non-applicable text or narrative**.

**Consideration of Additional Information & Interaction with other Resolution Mechanisms**

During the listening session hosted by the Departments on April 14, 2021, questions about the timeline with the Federal IDR process and how these might interact with plan/issuer appeals processes were raised. ACEP and EDPMA urge the Departments to ensure that the regulations reflect the following principles in this area:

- No plan or issuer may mandate an appeals process or other mechanism for out-of-network providers that alters the *No Surprises Act* obligation for an initial payment or denial of payment of the submitted CPT code within 30 days of claim submission. If plans and providers agree to adjudicate a claim through a plan's or issuer's established appeals process, no event associated with that process shall alter the *No Surprises Act* timelines.
- Regardless of the nature of any dispute that makes its way through the IDR process, a payment determination by an arbiter has no bearing on enforcement of plan/issuer obligations under the Prudent Layperson (PLP) Standard or causes of action or complaints filed with appropriate authorities, including penalties and retroactive rescission of problematic policies. Implementation policies for the *No Surprises Act* should not eliminate the right of providers to pursue appropriate remedies, including legal or other mechanisms, particularly when those remedies are not under the intended purview of the *No Surprises Act*. Each party's rights under law – outside of the *No Surprises Act* – should be reserved.

***ACEP and EDPMA urge the Departments to explicitly lay out these requirements in regulation to prevent any possible ambiguity around the health plan or issuer's initial responsibilities and to avoid any situations that would cause the entire process of negotiation and prompt resolution to be delayed or to never be triggered at all***.

## B. Batching

ACEP and EDPMA are of the strong opinion that the batching provisions of the *No Surprises Act* were included to ensure that there is an efficient way to dispense with disputes if they arise, to reduce overburdening the IDR process, and to encourage parties to limit the scope of claims taken to IDR. We believe the Departments must address the following issues in implementing rules related to the batching and allow parties the flexibility in which claims are carried into IDR.

**"Furnished by the Same Provider or Facility"**

While the Secretary has the authority to "specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity," the statute goes on to also state that it can only be applied to items and services "furnished by the same provider or facility."

ACEP and EDPMA believe that the Secretary should promulgate regulations that implement a definition of providers that reflects the statutory language and real-world claims processing practices. As such, we believe that this should include allowing for batching of claims for tax identification numbers (TINs) with multiple practitioners. This is consistent with the current Medicare approach to providers as a "Group Practice" under the Quality Payment Program and

how other Medicare programs are structured (e.g., the Center for Medicare and Medicaid Innovation (CMMI) BPCI Advanced model addresses site-specific practices as TIN entities).

In fact, with regard to the "initial payment," the statute even states, "*the group health plan or health insurance issuer . . . not later than 30 calendar days after the bill for such services is transmitted by such provider or facility,* **sends to the provider or facility, as applicable, an initial payment or notice of denial of payment**." (emphasis added). It would be unreasonable to implement measures that depart from the current practice of reimbursing claims to the tax entity that initially submitted the claim. We believe it follows that "provider" could be the billing entity or the individual physician, and, as such, "provider" should also be allowed to be the TIN submitting the claim for purposes of batching, if so chosen by the provider. Making this option available would reduce strain on the overall IDR process, reduce costs, and more accurately reflect current real-world claims processing logistics. Further, emergency physicians provide a wide variety of services as compared to physicians in other specialties, so it is much more difficult for an individual person providing emergency care to have enough "similar" emergency claims to obtain the efficiencies provided for by batching.

In summary, ***ACEP and EDPMA recommend that for purposes of the batching provisions, the Departments implement a methodology that allows a nonparticipating provider to choose to batch claims eligible for IDR either in the name of the individual or in the name of the physician group, identified by its Federal Tax ID number (TIN), for which the nonparticipating provider is a member***.

**"Related to the Treatment of a Similar Condition"**

The statute provides for batching of claims in the IDR process for items and services "related to the treatment of a similar condition." ***ACEP and EDPMA believe it is imperative that the Departments consider the goals of the legislation in light of the unique characteristics of the emergency department setting***. We do not believe that the law intended the implementation of a granular definition of "similar conditions" that prevents meaningful access to batching for emergency department providers. ***ACEP and EDPMA recommend that the Departments make explicit provision that in the emergency physician context, the "condition" is in fact "emergency medical care" or "EMTALA-related care."*** As you know, emergency care is different than scheduled surgery or office visits where the patient's diagnosis or condition is most often explicitly known. Conversely, the routine practice of emergency medicine is characterized by a range of severity that patients present with, and a corresponding range of diagnostic, therapeutic, and decision-making intensity. This is the essence of "emergency medical care," which is bound by EMTALA. While this most commonly results in claims based on seven CPT codes (99281- 99285, and 99291-99292) or submitted with Place-of-Service code 23 (*Emergency Room - Hospital*), "emergency medical care" is nonetheless the "condition" on which the Departments should base rules around batching for emergency services regardless of the codes billed or place of service in which the item or service was furnished. A contrary interpretation forcing emergency providers to limit IDR batching to granular, individual "conditions," which may even include diagnoses – which are often not known at the time that appropriate emergency care is rendered, would require a nearly endless series of adjudications, expense, and senseless administrative burden. We strongly encourage that this consideration – which is unique to emergency care – be given specific consideration in rule writing.

## C. 90-Day Cooling Off Period

**Batching Composition for Purposes of 90-Day Cooling Off Period**

Batching, as considered under the *No Surprises Act,* could result in different configurations of claims in any given dispute. Because the 90-day cooling off period was intended to apply to "like" claims following an IDR determination, ***ACEP and EDPMA recommend that the 90-day cooling off period apply to claims based on the same characteristics of the category (or batch) of claims that were the subject of an IDR payment determination.*** Neither providers nor plans/issuers should have additional, unlike claims affected during the 90-day cooling off period. Failing to address this possibility in rule writing may promote unnecessary and further utilization of IDR. The Departments should not incentivize parties to overload the IDR system with *all* claims eligible under statute for batching by requiring that any claim that *could have* been batched would be held in the 90-day cooling off period. **We believe the Departments can limit the incentive to move claims to IDR by setting policy that limits the 90-day cooling off period to only the collective characteristics of the claims in the "batch" that received an IDR payment determination.**

The list of characteristics should be based on at least the following:

- TIN/NPI combination;
- CPT code(s) involved;
- NSA-based geographic area from which the claims originated (e.g. only MSA 1 and 3 claims were batched and, therefore, only MSA 1 and 3 disputes could be held in the 90 day cooling off period, while MSA 2 disputes would continue under normal timelines);
- Provider type (i.e. physicians or NPPs);
- Insurance product type; and
- If batched by conditions involved (e.g. "emergency services related to abdominal pain"), then cooling off period application limited to those conditions

We believe this is appropriate for several reasons. First, **the statutory language is clear in its intent to only hold "like" claims in the 90-day cooling off period**. We believe putting clear parameters around this would help create a predictable, stable environment, which should reduce reliance on the IDR process by removing any incentive to batch everything-and-anything for fear that items and services will get held in the 90-day cooling off period. Second, **we firmly believe that the 90-day cooling off period creates a vulnerability for providers, and in particular small practices, because of the unilateral ability of plans to pay whatever they prefer in the 90-day cooling off period with no recourse for providers, thus putting them at risk of severe cash flow issues**. As discussed in more detail below, putting parameters around the payment in recognition of this dynamic is imperative and will help to make the *No Surprises Act* concepts more successful in achieving the goals of the legislation.

**Unreasonable Plan Payments during the 90-day Cooling Off Period**

As dictated by the *No Surprises Act*, IDR payment determinations commence the 90-day "cooling off period." However, an IDR payment determination does not inform the initial payment for disputed claims governed by the cooling off period. Given that the intent of the "cooling off period" (and other policies throughout the legislation) is to deter overreliance on IDR, it is important that the Departments focus on this component of the process to ensure that it does not become a vulnerability in achieving the goal of efficient and selective use of IDR.

For physician practices, managing cash flow is a key component of being able to ensure patient access to a sustainable service. **It is a fact that during the "cooling off period," the health plans/issuers are the only entity with dominion over the amount of reimbursements paid to providers, whose hands are tied for the ensuing 90 days with respect to their ability to dispute subsequent payment amounts via IDR**. Thus, health plans could technically make what are considered to be unreasonably low initial payments immediately following the IDR decision for the circumstance that was just adjudicated, with no threat of being taken to IDR in the short term, devastating provider or facility cash flow. The future risk of the provider initiating an IDR dispute could be outweighed by the benefits of the plan's increased access to cash. This introduces a dynamic whereby plans/issuers are positioned to capitalize on access to cash while reimbursing providers at rates that are neglectful of practices' ability to remain viable because of unnecessary interruptions in cash flow.

As well, if payers were to act in this manner, it would run contrary to the clear intent of this provision: to deter overreliance on the IDR process for resolving payment disputes that already have a pattern of resolution. This is a concern recognized by Congress in drafting the *No Surprises Act* (the Secretary must report on whether plans have a "pattern or practice of routine denial, low payment, or down-coding of claims" during the "cooling off period"). The Secretary should ensure that the framework of the *No Surprises Act* and the inclusion of the "cooling off period" are not undermined by this vulnerability in the process.

As such, ***ACEP and EDPMA urge the Departments to enact protections for providers and facilities from unreasonable initial payments from plans during the required 90-day cooling off period***. We look forward to continued conversation regarding potential solutions to prevent unnecessary cash flow disruptions and actions that could undermine the intent of the law, but emphasize that this is an important component of the federal IDR process to address to ensure that disputes held in the "cooling off period" do not unnecessarily move into IDR after the "cooling off period" ends.

We also believe that this has become even more vital in light of provisions included in the IFC published in the *Federal Register* on July 13, 2021 that would allow a plan/issuer to delay "initial payment" or "denial of payment" beyond "*not later than 30 calendar days after the bill for such services is transmitted by such provider or facility"* on the basis of whether it is a "clean claim." We believe that these are *precisely* the types of "opportunities to manipulate the timeline" that the *No Surprises Act* sought to avoid in its use of time certain terminology in the statutory language. Because this uncertainty has been injected into the process by the IFC, we believe it is critical that the Departments create protections on the back end by enacting protections for providers and facilities from unreasonable initial payments during the required 90-day cooling off period.

We would highlight that it is important that the Departments carry over its sentiment from the IFC that **"[i]n the Departments' view, the statute's reference to an "initial" payment does not refer to a first installment**" and that plans should be making what is reasonably expected to serve as the full initial payment. This is important not only for the financial viability of practices but also so that it decreases the likelihood that disputes need to rely on the IDR process.

It is critical that the Departments consider this in the context of the 90-day cooling off period when providers and facilities have no ability to use the IDR process to respond to unreasonable plan payments. Small practices and individual providers in particular will be particularly vulnerable to the ability of plans to complicate cash flow for claims held in the 90 day cooling off period. ***At the very least, ACEP and EDPMA believe that the Departments should create an explicit standard that they expect all parties to be acting in good faith with penalties to back up the Departments' expectations when that standard is not met***.

## D. IDR Criteria & Deliberations

**Weighting of IDR Payment Determination Criteria**

The *No Surprises Act* directs the arbiter to consider numerous criteria in rendering a determination. The criteria noted specifically in the law are:

- The qualifying payment amounts for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region as such qualified IDR item or service
- The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service
- The market share of the provider/facility or plan/issuer in the geographic region in which the item or service was provided
- The teaching status, case mix, and scope of services of the nonparticipating facility that furnished the item or service
- Demonstrations of good faith efforts (or lack of good faith efforts) made by the provider/ facility or plan/issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

***ACEP and EDPMA strongly urge the Departments to issue regulatory text that carefully defines the criteria in the IDR process that were laid out in the law, and specifically reinforces that no single criterion may be given undue consideration in the IDR process.***

Congressional intent in the *No Surprises Act* is clear: Congress purposefully chose no single criterion to be primary. In fact, in reinforcing this point further, key Senators in the passage of the *No Surprises Act* sent the Departments a letter reiterating what is clear from the plain text of the statute:

> *The law's arbitration framework is designed to ensure that neither payors nor providers have a financial incentive to remain out of network as a tool to establish leverage for contract negotiations.* ***To achieve this balance, we wrote this law with the intent that arbiters give each arbitration factor equal weight and consideration***.
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> *  *  *

> *Allowing groups to bring forward relevant information that arbiters will consider equally, while also excluding billed charges and public payor information from consideration, will allow for fair and clear determinations that reflect the specific circumstances of each dispute.*[2]

Further, a June 17, 2021 letter addressed to you and signed by 97 members of the House of Representatives stated:

> *The No Surprises Act instructs the certified IDR entity to consider each of these listed factors, as well as any allowable information brought by either party or requested by the certified IDR entity.* ***To match Congressional intent, your implementation of the law should ensure an IDR process that captures the unique circumstances of each billing dispute and does not cause any single piece of information to be the default one considered****.*[3]

We are concerned that without explicit regulatory language that prevents preferential weighting of any single criterion, there will be a drift toward preferences for certain criteria over time as a method for making the payment determination. If the Departments fail to render language that specifically prohibits preferential weighting of certain criteria and one of the factors that is preferentially used is the "median in-network rate," the *No Surprises Act* will function as a vehicle for rate-setting—which is in stark contrast to the intent of the *No Surprises Act* passed by Congress.

**Qualifying Payment Amount**

We recognize that in the IDR sections of the law that delineate the criteria for consideration, the language states that the QPA should be considered "*for items or services that are* ***comparable*** *to the qualified IDR item or service*" (in addition to the other parameters, e.g., "furnished in the same geographic region"). We believe that the word "comparable" was incorporated in order to provide flexibility so that some number might be used, but that a "comparable" number should not be used when a more precise amount is available. Thus, we believe the qualifying payment amount considered should be the one for the most closely appropriate item or service available. ***ACEP and EDPMA urge the Departments to ensure that rule reflects that the qualifying payment amount selected for consideration as part of the IDR deliberations shall be the QPA for the same item or service in dispute and that the QPA for comparable items or services shall only be relied on in instances where the QPA for the same item or service is not available***. Further, in order to ensure transparency and support negotiation, to the extent a plan ever makes a determination that the QPA for the Recognized Amount is a QPA for an item or service other than the exact item or service as billed by the provider, the plan must disclose both the QPA it intends to use for the Recognized Amount and the QPA for the specific items and services billed by the provider. In these hopefully limited instances in which disputes proceed to IDR, we believe that there should

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[2] Senator Bill Cassidy and Senator Maggie Hassan to Secretaries Beccerra, Walsh, and Yellen, April 29, 2021, https://www.cassidy.senate.gov/imo/media/doc/SMB%20Letter%20Final_4_29_21.pdf (accessed July 13, 2021).

[3] Signed Members of House of Representatives to Secretaries Becerra, Walk, and Yellen, June 17, 2021, https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2FSuozzi-Wenstrup-SMB-Implementation-Letter-w-signa-6.17.21.pdf.

be specific, data-driven information presented to the arbiter. To the extent that QPAs vary by insurance product, all information must be in front of the arbiter— including the QPA for the service as billed and documented by the provider.

**Availability and Accuracy of Information**

The availability of IDR in situations where disputes cannot be otherwise negotiated is a welcome component to the *No Surprises Act*. We request that the Departments take the following considerations into account during rulemaking:

- **Obligation to comply**: The *No Surprises Act* requires parties to submit information "as requested by the certified IDR entity related to such offer." We believe it is reasonable to expect that IDR entities could request submission of information related to all of the IDR criteria that are specifically identified in the statute. Whether the IDR entity request is related to the named criteria or some other information, we believe that the inclusion of the obligation of the party to comply is meant to ensure fair consideration of all available information.
- **Access to requested information**: We urge the agencies to ensure that requests for specific information (related to IDR criteria or other requests for information) do not create a disadvantage for a party that either (1) does not have access to information requested by the IDR entity or (2) one party has but the other does not (e.g., individual physician market share).
- **Data and information not submitted by either party**: We also request that the Departments provide guidance on information on which an IDR entity can rely that is external to data submitted by the parties. While we do not suggest that this would be in all cases inappropriate, we are concerned that IDR entity reliance on flawed data or information obtained from unknown sources and unvalidated for use in dispute resolution proceedings could undermine the intended process. In the case that data or information provided or obtained from neither party directly is considered in the IDR process, we believe that both parties should have access to that data or information, and be allowed to comment on its applicability, utility, and limitations for the IDR consideration at hand.
- **Additional information and opportunity for comment/rebuttal**: Finally, given the "10-day deadline" for submission of the parties, we also request that the Secretary provide guidance on the ability of parties to provide additional information after the "10-day deadline" in order to complement or rebut information submitted by the opposing party. A system that encourages IDR entity reliance on incomplete or flawed data or information submitted by a party will not generate fair or reliable outcomes.

## E. Additional Policies to Support an Effective Federal IDR System

**IDR Entity Certification Criteria**

We believe that the certification of IDR entities is the first step to setting up a federal IDR system that functions as the law intended. ***ACEP and EDPMA urge the Departments to implement an IDR system that decreases system costs and efficiently administers the intended goals of the No Surprises Act***. As our members have been participants in various state mechanisms set up for out-of-network IDR or arbitration, we have observed IDR entities with demonstrated variation in their efficiencies and productivity. As the HHS Secretary is given the authority to certify entities for

participation in this process, such certification process should ensure an evaluation of the IDR entity's IT efficiencies and administrative costs.

**IDR Entity Fees**

***ACEP and EDPMA believe the Departments must ensure that the IDR entities available for selection are neither costly nor bureaucratic entities that create a cumbersome, costly federal IDR process***. In Texas, for example, which provides a state-based mechanism to access IDR, providers have found the costs associated with arbitration to be a meaningful barrier to IDR access, and that payers have used arbitration fees as a method for putting pressure on practices that are less able to withstand disruptions in cash flow.[4] We recognize that this is partially a byproduct of mediation fees being split by the parties under Texas law, no matter the outcome. While the *No Surprises Act* requires that the losing party is the only one subject to the IDR fees, thus partially protecting from this dynamic, it demonstrates the importance of preventing the use of IDR fees as a tool by certain parties to manipulate the system. Thus, the Secretary's certification process should ensure that the certified IDR entities in a given area do not charge excessive fees.

**IDR Entity Conflicts**

In order to ensure a process that supports the goals of the No Surprises Act, ***ACEP and EDPMA urge the Departments to promulgate selection criteria that ensure that dispute parties have access to multiple organizations that are not only free from direct conflict with potential parties, but that are also free from a general bias toward either plans/issuers or providers***. While the law provides restrictions on IDR entities from overseeing disputes that have a direct conflict with parties to the dispute, we are concerned that this does not account for general IDR entity bias or conflict. For instance, we do not believe that an entity that has a connection (even if not a direct "affiliate or subsidiary") with one payer should be allowed to serve on the list of potential IDR entities, even with the caveat that the entity would refuse to oversee a dispute regarding the exact payer with which it has the connection. Allowing for this IDR entity to be on the list does not address potential bias in the direction of one type of party in the dispute. We believe this should hold for entities with a general connection to provider organizations or provider professional or trade associations.

In addition, while the statute provides that IDR entities may not be the employee or agent of a party or have a familial, financial, or professional relationship with the party, or otherwise have a conflict of interest with a party, the parties are of course not yet knowable at the time of IDR entity certification. Thus, **the regulations should provide confidence that IDR entities with potential bias toward a particular type of party are not certified to be included in the list of eligible IDR entities**.

[4] *See*, https://www.tdi.texas.gov/reports/documents/SB1264-preliminary-report.pdf (accessed July 19, 2021).

**IDR Payment Determinations- Delays in Plan/Issuer Payment**

Once an IDR determination is made, the non-prevailing party will need to make up the difference with the prevailing party within 30 days, as per the statute. If such a payment is not made by the end of the 30-day period, interest should apply. ***The Departments could consider setting the interest rate at the rate which HHS currently applies to overdue and delinquent debts, pursuant to 45 CFR Part 30—which is determined and fixed by the Secretary of the Treasury***.

Thank you for the opportunity to provide feedback. If you have any questions, please contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs at lwooster@acep.org, or Elizabeth Mundinger, EDPMA's Executive Director at emundinger@edpma.org.

Sincerely,

Mark S. Rosenberg, DO, MBA, FACEP
ACEP President

Bing Pao, MD, FACEP
Chair of the Board, EDPMA